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Ministry of Health and Social Welfare

Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Maternal Neonatal and Child Health

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Mid Term Review of the Health Sector Strategic Plan III 2009-2015

Maternal Neonatal and Child Health

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Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
AMMP	Adult Mortality and Morbidity Project
AMO	Assistant Medical Officer
ANC	Antenatal Care
AIDS	Acquired immunodeficiency syndrome
AFSRH	Adolescent Friendly Sexual Reproductive Health
ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioural Change Communication
BCG	Bacillus Calmette–Guérin
BEmONC	Basic Emergency Obstetric Neonatal Care
CAG	Controller and Auditor General
CBDs	Community based Distributors
CCHP	Comprehensive Council He
CEmONC	Comprehensive Emergency Obstetric Care
CHF	Community Health Fund
CFR	Case Fatality Rate
CHF	Community Health Fund
CHMT	Council Health Management
CHWs	Community Health Workers
CIDA	Canadian International Development Assistance
CS	Caesarean Section
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
CTC	Care and Treatment Centre
CYP	Couple Years of Protection
DC	District Council
DHIS	District Health Information System
DFID	Department for International Development

DOT	Direct Observed Treatment
DPP	Directorate of Policy and Planning
DTP	Diphtheria, Tetanus, Pertussis
EBF	Exclusive Breast Feeding
EID	Early Infant Diagnosis
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and New-born Care
eMTCT	Elimination of Mother To Child Transmission
EPI	Expanded Programme on Immunization
FANC	Focused Neonatal Care
FP	Family Planning
FBO	Faith-Based Organization
FY	Financial Year
GAIN	Global Alliance for improved Nutrition
GOT	Government of Tanzania
HC	Health Centre
HDSS	Health Demographic Surveillance Site
HF	Health Facility
HKI	Hellen Keller International
HCT	HIV Counselling and Testing
HIV	Human immunodeficiency virus
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IEC	Information Education Communication
LGA	Local Government Authority
MDGs	Millennium Development Goal(s)
M&E	Monitoring and Evaluation
MKUKUTA	[National Strategy for Growth and Reduction of Poverty]
MMAM	MpangowaMaendeleowaAfyayaMsingi [PHSDP]
MMR	Maternal Mortality Ratio
MO	Medical Officer
MOF	Ministry of Finance
MOHSW	Ministry of Health & Social Welfare
MOI	Muhimbili Orthopaedic Institute

MNCH	Maternal, Neonatal and Child Health
MRDT	Malaria Rapid Diagnostic Test
MSD	Medical Stores Department
MTC	Medicines Therapeutics Committee
MTEF	Medium Term Expenditure Framework
MTUHA	[Health Management Information System]
MOHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NCD	Non-Communicable Diseases
NEHP	National Essential Health Package
NGO	Non-Governmental Organization
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
P4P	Pay for Performance
PECS	Post Event Coverage Survey
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PHSDP	Primary Health Services Development Plan [MMAM]
PID	Pelvic Inflammatory Disease
PLHIV	Persons Living with HIV/AIDS
PMI	President's Malaria Initiative
PMO-RALG	President's Office – Regional Administration & Local Government
PNC	Post Natal Care
PMTCT	Prevention of Mother to Child Transmission
RCH	Reproductive and Child Health
RHMT	Regional Health Management
SARA	Service Availability and Readiness Assessment
SP	Sulphadoxine-Pyrimethamine
SPD	Sentinel Panel of Districts
SUN	Scaling Up Nutrition
SWAp	Sector-Wide Approach
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis

TC	Town Council
TDHS	Tanzania Demographic & Health Survey
TFNC	Tanzania Food and Nutrition Commission
THMIS	Tanzania HIV and Malaria Indicator Survey
TIKA	TibaKwaKadi [urban community health fund]
TOR	Terms of Reference
TQIF	Tanzania Quality Improvement Framework
TSPA	Tanzania Services Provision Assessment
TT	Tetanus toxoid
TWG	Technical Working Group
TZS	Tanzania shillings
UNICEF	United Nations Children's Fund
U5MR	Under-five Mortality Ratio
USD	United States Dollar
USAID	United States Agency for International Development
USSD	Unstructured Supplementary Service Data
UTI	Urinary Tract Infection
VAD	Vitamin A Deficiency
VAS	Vitamin A Supplementation
WFP	World Food Programme
WHO	World Health Organization
ZHRC	Zonal Health Resource Centre

I. Introduction

This report is part of a set of reports of the Mid Term Review (MTR) of Health Sector Strategic Plan (HSSP) III (2009 – 2015) (MOHSW 2008a). In addition to the general report, there are eight specific reports to report findings related to: General Service Delivery, Maternal Neonatal and Child Health (MNCH), Social Welfare, Human Resources for Health (HRH), Pharmaceutical Services, Monitoring and Evaluation M&E), Capital Investments and Health Financing. This report covers MNCH issues.

The persistently high maternal, newborn and child morbidity and mortality rates over the past two decades in African countries including Tanzania makes the reduction of maternal, newborn and child deaths a high priority. As such, it is one of the major concerns addressed by various global and national commitments in Tanzania such as the Millennium Development Goals, Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health Services Development Program (PHSDP-MMAM), among others. The Maternal Mortality Ratio (MMR) has remained high in Tanzania for the last 10 years without showing much decline. However, significant progress has been made to reduce child mortality in Tanzania (MTR-AR 2012).

Tanzania developed a plan to reducing maternal, newborn and child mortality in line with the New Delhi Declaration 2005. Following the launch of the Tanzania Partnership for Maternal, Newborn and Child Health (TPMNCH) in April 2007, further support for incorporating child health interventions into this plan was voiced by various stakeholders and development partners. The Maternal Newborn and Child Health Strategic Plan in Tanzania (2008 – 2015) was subsequently developed as Tanzania's national response to the renewed commitment to improve maternal, newborn and child care (MNCH). The primary purpose of the this one Plan "is to ensure improved coordination of interventions and delivery of services across the continuum of care" MOHSW 2008. This plan also includes specific attention on the need to improve coordination, alignment of resources and standardisation of monitoring (MOHSW 2008).

2. HSSP III Health Strategic Objectives and Expected Results

MNCH Strategies

1. Increase access to Maternal, Newborn and Child Health (MNCH) services
2. Strengthening the health systems to provide quality MNCH and nutrition

According to HSSP III, the One Plan for Maternal Newborn and Child Health is the core strategy for improvement of MNCH, accepted by all stakeholders.

Increasing access to MNCH interventions is also part of the MMAM programme. Increased coverage of primary health care in remote areas provides MNCH closer to the community. The key focus in HSSP III is on increasing proportion of skilled attended deliveries, providing Emergency Obstetric Care (EOC) and Family Planning. Guidance exists on which MNCH services should be delivered at each level, and increasing the number of health facilities that can provide the appropriate MNC will reduce maternal and neonatal mortality.

The One Plan envisages that provision of Adolescent Friendly Reproductive Health (AFSRH) services will be promoted and availability of Family Planning (FP) methods and child health interventions will be increased. MOHSW envisages a strengthened health system capable of providing quality MNCH services. In this regard MOHSW will review regulations, guidelines and standards, and will also improve standardised supervision, at all levels of the health services. This will result in evidence-based interventions at facility level. Improving the workforce in health facilities will not only be in numbers but also in competencies to provide quality MNCH.

Improving quality of MNCH services is also part of the Tanzania Quality Improvement Framework (TQIF), to be implemented in a comprehensive context across the sector. The MNCH strategy envisages a stronger linkage with other relevant programmes to enable health facilities to provide appropriately integrated MNCH services and other related services. The strategy also include strengthening the referral system and the response to improved obstetric and newborn emergencies through better provision of equipment and supplies, as well as means of communication and transport. The MOHSW aims at increasing resources for MNCH through advocacy with policy makers and planners (also in LGAs), as maternal and child health is dependent on so many other factors, besides health care provision (e.g. nutrition, education, access to safe water)(MOHSW 2008).

3. Findings and Issue per Strategic Objective

3.1 Maternal Health

According to the Tanzania Demographic Health Surveys (TDHS2010), MMR is slowly decreasing from 578 per 100,000 live births in 2005 to 454 in 2010, and the progress towards MKUKUTA target (MMR 265 by 2010) is slow. Given that the average percentage decline in MMR per year between 2005 and 2010 was 4.3%, it will take 19 years up to 2029 for Tanzania to reach MDG5 target (MMR 193 by 2015) if the current rate of decline continues. In order to achieve MDG5, the average decline rate should be heightened up to 11.5% per year (MTR-AR 2013).

3.1.1 Antenatal Care (ANC)

Utilisation

MoHSW has promoted a four-visit Focused Antenatal Care (FANC) approach since 2002 (TSPA 2006). ANC services are provided free of charge.

With funding from USAID, ACCESS worked with MOHSW to develop and scale up FANC. Through this program support 4,536 out of 6,000 ANC providers were trained in FANC (76% coverage). Additionally 845 providers from 559 facilities were trained in 37 districts using funding from UNICEF, UNDP and Christian School Services Commission, and quality improvement was introduced in 2,366 facilities representing 55% nationally (ACCESS 2010).

Almost all pregnant women in Tanzania (98%) received at least one ANC visit in 2010 (MTR-AR 2013). Although the policy is to start attending ANC before the 16th week of gestation, in 2010 over 80% of pregnant women initiated ANC later than 17 weeks of gestation (similar to the pattern found in 2004/2005 (TDHS 2005; 2010). The percentage of pregnant women who had ANC 4 declined remarkably from 64% TDHS 2004/5) to 43% in 2010 (TDHS2010)¹. The 2015 target is 90% and unlikely to be met.

Quality

Various researchers have studied the phenomenon of low follow-up utilization of ANC, who come with underlying causes (Sarker et al 2010). An exploratory study (Shivam Gupta et. al 2011) found that women residing in the Eastern zone had the highest ANC 4 utilization. All other administrative zones were associated with lower attendance of ANC 4.

A number of studies have reported the positive association between higher quality of services and higher rates of utilization of maternal health services including ANC4, (Shivam Gupta 2011; Lule et al. 2000; Mselle 2013; Mathole et al. 2004; Plotikin et al. 2010).

The nationwide Tanzania Service Provision Assessment (TSPA 2006) studied the availability of services during ANC. Facilities in the western zone and southern highlands scored among the lowest (TSPA 2006). Yet, the eastern zone scored the highest on availability of quality ANC services. High maternal

¹ The median coverage rate of at least one ANC visit is 88% and four or more ANC visits is 55% in low income countries according to the countdown to 2015, where 69 countries were tracked (Requejo et. al 2012). The Tanzanian ANC4 visits is lower than the median of 55% for low income countries.

education was also strongly associated with ANC 4. This finding reflects the fact that higher education is also associated with increased financial and geographical access to health services. ANC4 decreased with long distance and/or long length of time taken to get health services and perception of poor quality of care both by providers and women (TSPA 2006; Plotkin et. al 2010; Mselle et. al 2013). Another study by Mrisho 2009 notes that late initiation of ANC is actually a conscious decision by some women who want to avoid making several visits to the clinic. Health promotion of the benefits of more visits need to be improved especially highlighting the specific services required for the ANC4 recommended visits.

Women in urban areas are more likely than women in rural areas to attend ANC4 (55% versus 39% respectively) (TDHS2010). Further analysis shows that pregnant women who start ANC late (like after 4 months of gestation) fail to make ANC4. Hence, it is important to promote early ANC attendance at 16 weeks, especially in rural areas where it is low.

About 68% (TDHS2010) of the women had their blood pressure measured and 77% had their blood samples taken for haemoglobin estimation and syphilis screening and PMTCT 86% (MOHSW 2012). About 52% had urine analysis done (MTR-AR 2013).

Plotkin et al. in 2010 found that the provision of key services for ANC ranged from high coverage of weighing clients (84%), measuring blood pressure (79%), providing intermittent preventative treatment for malaria (IPT) (65%), to taking blood tests for anaemia (53%) and screening for syphilis (52%). These key services did not differ greatly among regional hospitals and health centres and dispensaries. The largest difference was in measuring blood pressure: whereas 93% of clients in regional hospitals had their blood pressure taken, 75% of the clients in health centres and dispensaries had blood pressure taken. Overall, the lowest scored area was the urine test for protein, which 39% of clients received, followed by counselling for family planning, which 49% of clients received (TDHS2010).

Field visits to 3 selected regions during this MTR indicated shortage of reagents for syphilis tests, stock outs of SP, Ferrous Sulphate, and lack of BP machines, haemoglobinometer, ANC cards. Stock outs of albendazole, ferrous folate were documented in the End User Verification Survey (MOHSW 2013).

This raises the question of the quality of ANC provided to pregnant women. The Community Perspective study for this MTR confirmed the picture, that women consider the quality of ANC to be poor.

Services during Antenatal Care

TTV

Tetanus Toxoid Vaccination (TTV) is recommended to be given twice (TT2) during a pregnancy. Fewer pregnant women received TT2 during 2006-10 (48%)(TDHS 2010) than during 2000-04 (56%). The 2010 TDHS shows variations in the proportion of pregnant women with two or more doses of TTV, from 23% in Kagera to 71% in Arusha, with variations according to level of education and wealth quintiles. Younger mothers, women with a first pregnancy, women of the higher education and wealth strata and urban women are more likely to receive two or more doses of TTV. The TDHS 2010 also collected information on the indicator of lifetime protection against tetanus. In Tanzania, approximately 88% of pregnant women had obtained lifetime protection.

HIV Testing and PMTCT

Tanzania is currently implementing a national elimination strategy of mother to child transmission (2012 – 2015), with the aim of reducing vertical transmission rates to below 5% by 2015 (MOHSW 2013). According to UNAIDS estimates, new paediatric HIV infections have decreased by 19% from 2005 to 2010 (from 26,900 to 21,900). HIV prevalence among pregnant women was 7% in 2008 (MOHSW 2013).

Prior to the current plan, Tanzania was implementing the National scale up plan for PMTCT 2009-12 that translated the national HSSP III targets, and National Maternal New-born and Child health strategy goals that aimed to achieve universal access (80% access to PMTCT by 2012), and to improve child survival among HIV-exposed and infected children by 50%. During the scale up implementation, access to HTC and provision of ARV continued to increase, appearing to meet the HSSP III national targets. In 2010, about 86% of the pregnant women who attended ANC, were tested for HIV. In 2011, 74% of pregnant women living with HIV received efficacious ARV regimens for PMTCT, a huge increase from 34% in 2009.

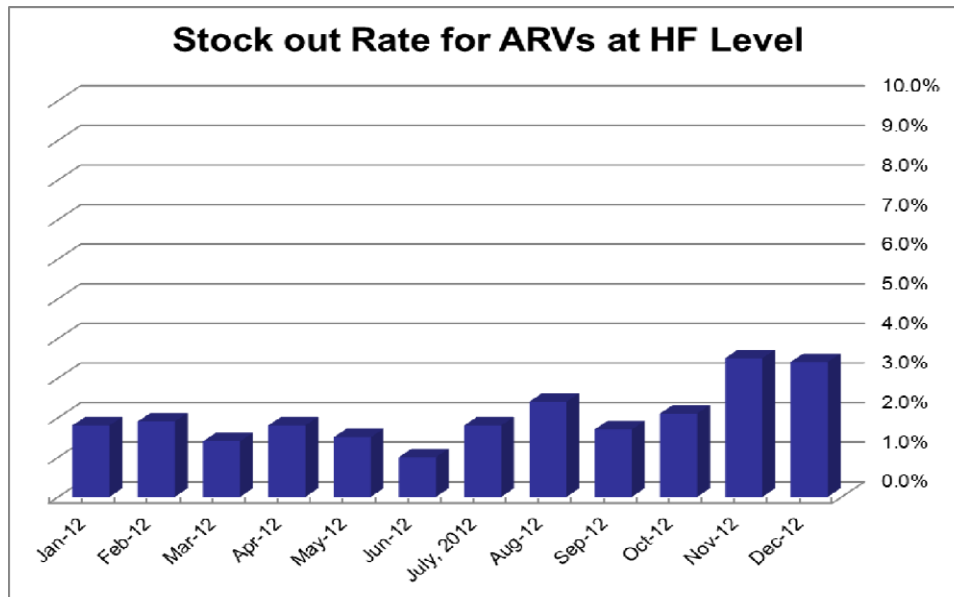
A number of women and their children are still not reached with PMTCT services, despite high ANCI+(>95%) coverage (MOHSW 2013; MTR-AR 2013).

In 2010 about 66% of first-visit ANC clients were referred for or received HIV testing and 59% received or were referred for counseling (Plotkin et al 2010). Another study found strong association between increased ANC visits of 4 or more and availability of PMTCT (Shivam Gupta et. al 2011). If PMTCT services are improved and scaled up, they will in tandem increase the number of ANC visits.

According to the eMTCT bottleneck analysis (MTR-AR 2013), there is good access to PMTCT provided in about 93% of health facilities offering MNCH services. The proportion of facilities that offered maternal ARV prophylaxis almost doubled to 68%. ART coverage rates are on target and have increased to 53% (65% for adults and 31% for children). Treatment is initiated earlier and survival rates in the first year have improved to 92.7 % among those who initiated in 2010(MTR- AR 2013). However, a major challenge remains loss to follow up from the initial ART clinic, standing at 25 % in 2012(MTR- AR 2013).

Often facilities offering PMTCT services have trained staff, guidelines, and diagnostic ability in the form of rapid HIV tests) (UN 2012). The field visits during this MTR found that option A intervention (complex regimen) are offered and Nevirapine for neonates had been out of stock since December 2012. In Geita region, for example, the district hospitals often run short of reagents for blood grouping and uni-gold for confirming HIV positivity. There was also a reported frequent shortage of HIV testing kits in Geita region, to the extent that the demand for PMTCT, CTC, PICT and VCT could not be met. In Mbeya region, in some cases the CD4 machine was not working like at Mbeya City; there were no cartridges for puma machines so they ended up not being used. Among the facilities offering ANC services, 49% had a staff member trained in ANC and 60% had guidelines. Diagnostics were mostly not available, and in 2012 the situation was poorer than in 2008/09: where only 8% could do an Hb test on site in 2012, down from 21% in 2008/09. Urine dipstick (protein and glucose) were available in one fourth of clinics in 2008/09, and only one in 6 in 2012 (Plotkin et. al 2010). In some cases lack of DBS for early infant HIV diagnosis was noted see figure I below illustrates stock-out of ARVs in HF (MOHSW 2013).

Figure I Stock-out rate of ARV



Source: MOHSW 2013

From 2011 to 2012 there was a bit of change in the trend, as in 2012 the country experienced shortage of HIV test kits, which resulted in the decline of the number of pregnant women counselled and tested for HIV. About 1,381,022 and 1,036,948 pregnant women were counselled and tested for HIV in 2011 and 2012 respectively. (MOHSW 2013).

An investigation of possible reasons for the decline also suggested that policy changes may contribute to reduced visits. Most lab tests are done at first visits and the women are supposed to come back on specific dates. Women do not adhere to those appointments.

PMTCT coverage by 2013 is 4,914 where facilities providing EID are 1,560 (34%). The shortage of DBS test kits and HIV test kits was reported country-wide, proportion of pregnant women tested at ANC has significantly decreased from (82%) to 64% 2010-2011 respectively, this drop was explained by shortage of HIV test kits in 2012(MOHSW 2013)

Testing of HIV exposed infants is still low, the trend has been 22,033 (25%), 27,245 (29%) and 26,608 (32%) for 2010, 2011, and 2012 respectively. There are multiple factors contributing to this low percentage, some being low coverage of the EID services, shortage of DBS test kits and loss to follow up of the mother and the infant. According to information from laboratory provided to the PMTCT program the median for EID is reportedly at 5 months. (MOHSW 2013)

In 2012, there was a 30.2% increase in referrals from HTC to PMTC (MOHSW 2013). The country has a total of 382 PIMA machine, which are point of care for CD4 testing. CD4 testing machine increase uptake of CD4 testing for pregnant women and most of these machines are located at the RCH units in the facilities.

Health centres and dispensaries have the highest ANC caseloads and also are the point of entry for PMTCT. Strengthening ANC will have a positive effect on PMTCT.

Intermittent Preventive Treatment for Malaria

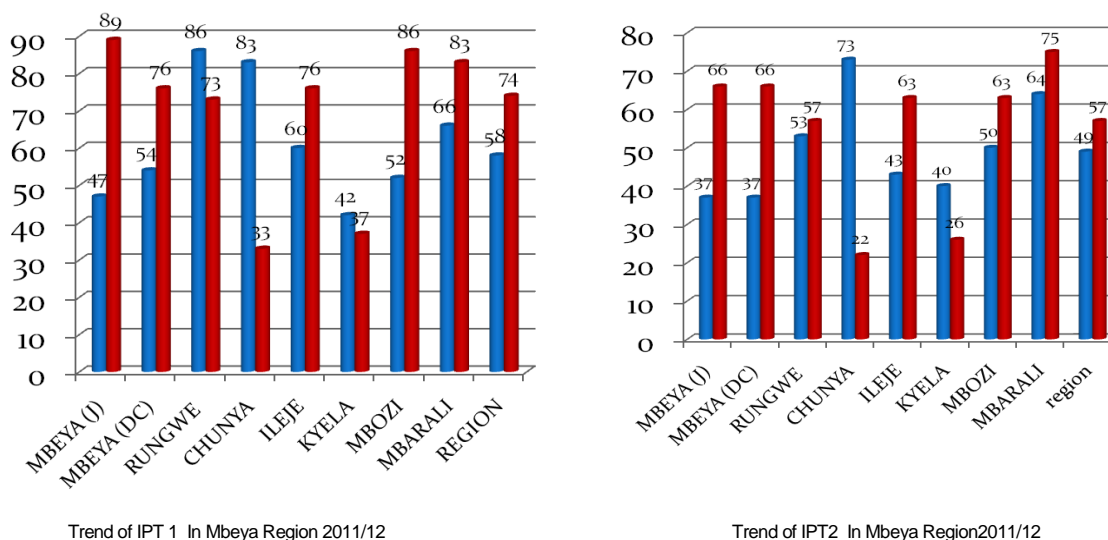
Malaria prevention is integrated in ANC services through ensuring access to subsidized Insecticide Treated Nets (ITNs) distributed through a voucher scheme, which is known as Hati Punguzo. The voucher scheme started in October 2004 and by May 2006 it was scaled up to all districts (Hanson K.et al. 2008). According to the HIV/AIDS and Malaria indicator survey 2011-2012, about 68 % of pregnant women in Tanzania slept under any net the night before the survey, 57% slept under an ITN and 72 % of children aged under 5, slept under an ITN the night before the survey (TACAIDS 2012).

IPT

A second strategy of malaria prevention in pregnancy being used in Tanzania is provision of malaria prophylaxis, whereby pregnant women receive two doses of Sulphadoxine Pyrimethamine (SP) for Intermittent Preventive Treatment (IPT) during routine ANC visits. The current policy is Direct Observed Treatment (DOT) for IPT given twice. A considerably large percentage of women attend ANC twice (94 %), yet few pregnant women received IPT 2. According to the THMIS 2011/12 data only 31 % of pregnant women received IPT2 versus 58 % who received IPT1 (HIV/AIDS and Malaria indicator survey 2011-2012). Nationally the percentage of pregnant women who received IPT2 remains very low at 27% (HIV/AIDS and Malaria indicator survey 2011-2012).

This progress is very slow to reach the 2015 target of 80 % of pregnant women who receive IPT2. This low coverage of IPT2 was also observed in most districts in Mbeya region in both 2011 and 2012 (see fig 1 below). Stock outs of SP were observed during the MTR field visits and also documented in the end user verification study see figure 2.

Figure 2 Trend in IPT in Mbeya Region 2011 -2012



3.1.2 Delivery Care

Delivery by Skilled Attendants

Tanzania has made much slower progress than the 11 sub-regional countries group where skilled birth attendant (SBA) coverage increased from 43% to 59% of deliveries during 2005-2010. Tanzania's SBA (51%) has actually dropped from the 5th to the 8th place among the 11 countries (MTR-AR2013).

The MMAM policy aims at having a dispensary at each village and a health centre in every Ward (a ward covers 4-6 villages). The policy in Tanzania is to encourage all women to deliver in a facility. Not all these

health facility deliveries are with a skilled birth attendant. According to the TDHS 2010 only half of the births nationwide occur in health facilities. Home deliveries are more common in rural areas (56%) compared to urban areas (17%). Women in the highest wealth quintile are more likely to have a skilled assistance during childbirth than women in the lowest wealth quintile (90% vs 33%). There is also a wide regional variation in SBA. Over 80% in Dar es Salaam, Kilimanjaro and Ruvuma regions and below 33% in Kigoma, Mara and Shinyanga regions (TDHS 2010).

Compared to the TDHS 2010, the Midterm Review Analytical Report indicates that HMIS data for 2012 shows a gradual increase in facility delivery to 52% and the NPS 2010 showed a SBA rate of 62 % as shown in the figure 3 below (MTR-AR2013). Some of the barriers faced by women in accessing care, include distance to the health facility, lack of money and transport, and the perceived poor quality of care, including non-availability of competent provider (TDHS 2010; Pfeiffer 2013). In addition, some women may still prefer to deliver at home with Traditional Birth Attendants (TBAs) for various reasons; including trust in TBAs, perception that TBAs are more experienced compared to the available health providers at the PHC facilities, as was observed in the ethnographic study done in Dodoma region (Lugalla et al 2011). However, other studies have documented women dissatisfaction with TBAs, and that the barriers faced by women are the main reason for low utilisation of facility delivery services. (Pfeiffer & Mwaipopo 2013; Mbaruku et al. 2009).

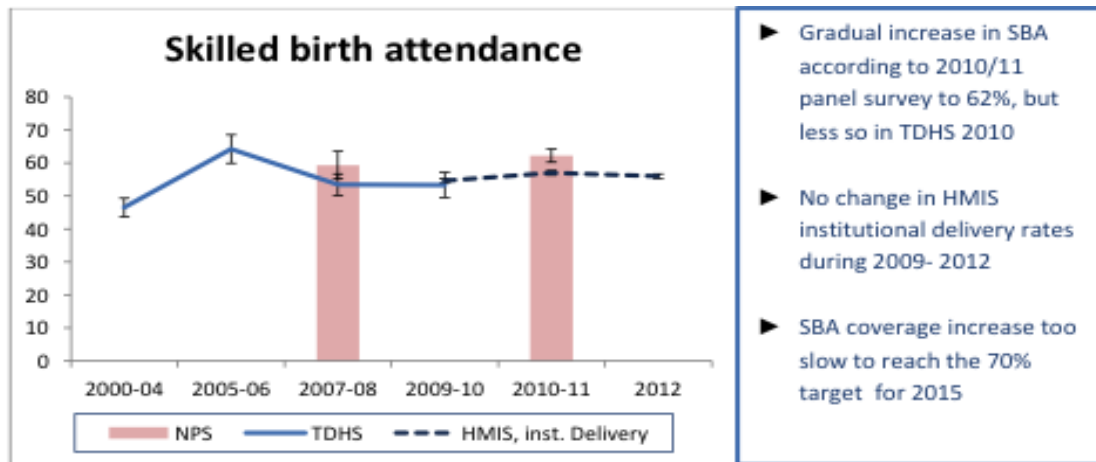
Studies have shown that the poor attitude of health providers and lack of respect of the provider, including use of abusive language, also contribute to women preferring home deliver (REPOA Working Paper 13/1, 2013; Mselle et al. 2013). Other challenges at health facilities include chronic shortage of health providers, shortage of supplies and medicines, inadequate infrastructure- including space, delivery beds, water availability and light source. Due to these shortages women are often asked to bring a list of items, as well as make other unofficial payments should they opt for facility delivery, even though the services are supposed to be free of cost. This is increasing out of pocket expenditure for women who seek facility-based delivery (PEPOA Working paper 13/3; Care International & Women's Dignity, 2008; Rijsbergen B and D'exelle). The MTR field visits found that women need to bring gloves, cotton wool, syringes, razorblades, and mackintosh, two buckets of water, kerosene and oxytocin drugs, as well as their own linen. This long list discourages women, especially the poor who cannot afford to purchase the listed items.

On the other hand the perceived poor quality of care also causes even poor women to bypass nearby public primary health care facilities, and deliver at private not for profit health facilities (FBOs), where the quality is perceived to be much better in comparison to public health facilities. For example a study done in one poor rural district (Kasulu) by Kruk et al. 2009) showed that 40% of women who choose to deliver in health facilities, bypassed their nearest health facility choosing to deliver at the government hospital or at mission facilities. The main reason was the perceived better quality of care provided and availability of competent staff (Kruk et al 2009). A recent study using Ifakara Health Demographic Surveillance Site data (HDSS in Southern Tanzania) showed that neonates delivered in health facilities experience a similar level of mortality as those delivered in the community. Poor quality of care in health facilities was documented, and was associated with inadequate skilled staff and shortage of basic equipment and supplies (Nathan & Mwanyangala 2012).

The figure 4 below from the end use verification survey demonstrates some of the stock outs in MNCH.

In an on-going initiative by MOHSW being piloted in two regions (Dodoma and Pwani), women receive delivery kits (mama kits) that contain all essential supplies for a clean delivery and misoprostol. It is assumed that possession of the kit will encourage women to utilize health facilities for delivery care. We were informed that 127,000 kits would be distributed, while so far already 40,000 have been distributed. No outcomes have been recorded yet.

Figure 3 Trend in skilled birth attendance (various sources)



Source: MTR –AR 2013

BEmONC and CEmONC

In Tanzania Basic Emergency Obstetric and Neonatal Care (BEmONC) is provided at primary health care facilities (dispensaries and Health centres, while Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) is provided in hospitals and upgraded health centres. Community based mobilisation and empowerment at the same time should improve health seeking behaviour and utilisation of essential maternal health services.

The table below show achievements in BEmONC and CEmONC compared to the One Plan targets.

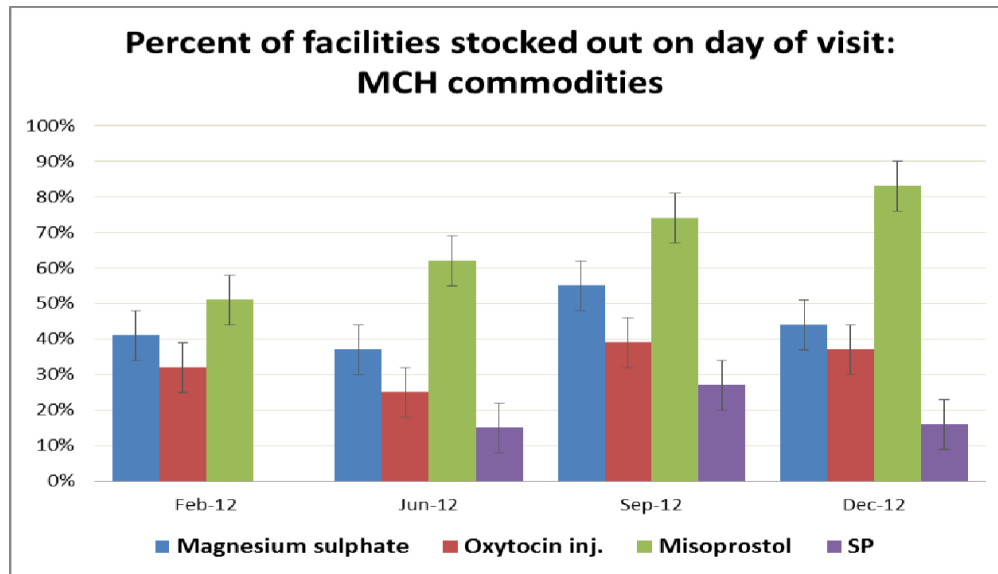
Table I BEmONC and CEmONC Performance

	BEmONC Target	BEmOC Baseline 2007	BEmOC Provided 2012	CEmONC Target	CEmONC Baseline 2007	CEmOC Provided 2012
Dispensaries	70%	5%	20%			
Health centres	70%	5%	39%	50%		
Hospitals				100%	65%	73%

Source: SARA 2012

During MTR field visits, it was observed that the frequent stock out of essential supplies including MgSO₄, oxytocin, disinfectants, gloves and sutures, as well as the lack of skills to provide some of the BEmONC functions (such as MVA and Vacuum deliveries) was a major challenge to scaling up BEmONC.

Figure 4 Stock-out of MVH commodities



Source: MOHSW 2013 Tanzania: Strategic Review of the National Supply Chain for Health Commodities

According to the SARA 2012, only 12% of the facilities had MVA kits, 12% had D&C kits and 29% had an examination light source. Specifically less than a third of Health centres had either an MVA kit or a D&C kit. Studies show that other essential BEmONC interventions, such as proper use of partogram for monitoring labour, and AMSTL are infrequently practised (Leshabari et al2010, Plotkin et al2010).

In many regions construction and expansion of rural health centres (constructing theatre and labour wards) is undertaken, often with support from donor organisations. Other support includes training of AMOs and anaesthetists on BEmOC and CEmONC, equipment, medicines and supplies.

Examples of initiatives supporting expansion and construction of health facilities include the one supported by the World Lung Foundation operating in Pwani, Morogoro and Kigoma regions. The UN also supports similar programmes in Dodoma and Shinyanga region. However there was no data available on actual overall performance of these programmes.

Anecdotal evidence suggests, there is lack of coordination of these programmes. Some of the partners support or promote single interventions e.g. supply of equipments, distribution of delivery kits, or post abortion care (PAC), HBB etc... This leaves gaps in comprehensive improvement of care, and does not yield required results. Overall, CEMONC is lagging behind in its efforts to meet the stipulated targets. MOHSW is planning a mapping exercise to get an overview of BEmONC related activities in the health sector.

Delivery by Caesarean Section

WHO recommends a minimum of Caesarean Section (CS) delivery of 5 to 15 %. According to the TDHS 2010, the CS rate was only 4.5 %. CS delivery is not equitably distributed it varied according to urban/ rural, geographical zone and by wealth strata. In rural areas the CS rate was 3.2 versus 9.6% in urban areas. Greater disparities are observed when it comes to wealth quintiles with CS rate, being only 1.2% among women in the lowest wealth quintile compared to 12% among the highest quintile. Thus the rural poor have limited access to life saving obstetric surgery. Studies show that women who develop complications face barrier to accesses care, both before and after arriving at health facilities. The delays are caused by lack of decision making power by the women, distance and lack transport (level I & II delay), and at health facility/hospital level lack of equipment, medicines and supplies, lack of skilled

staff, and poor staff attitude (level III delay)(Mselle et al 2011; Mackintosh et al 2013; Penfold ET AL. 2013).

Another major constraint in the provision of CEMONC is unavailability of safe blood supply. During MTR field visits it was pointed out that the districts/regions have no capacity for safe blood transfusion so they rely on Zonal centres which are far away and provision of safe blood from these centres is inadequate and not timely for lifesaving of obstetric emergencies.

Referral

Reducing maternal and newborn deaths require a functioning health system including effective communication and transport to ensure a prompt referral in the event of an obstetric emergency. A recent national survey showed that only 52 % of public facilities that provide delivery care, had emergency transport available (SARA 2012). However this is an increase compared to the 2006 Service Provision Assessment Survey, which showed that only 40% of the facilities had emergency transport available (TSPA 2006).

During the MTR field visits, the districts visited had few ambulances inadequate to cater for all medical referral cases including MNCH. In some cases where transport is difficult, women spend the last few weeks at a waiting home constructed near the referral hospital, so that emergency obstetric care is readily available. This is the case in some districts in Tanzania (including Chatto district). However, the extent of this intervention has not been well documented and evaluated. In Ileje district motorcycle ambulances were introduced to improve referrals, but the difficult geographical terrain rendered the use of these motorcycle ambulances ineffective and unusable. The MOHSW has distributed about 400 ambulances in recent years; however, this intervention is yet to be evaluated. Other on-going initiatives include establishment of community funds to support pregnant women during emergencies. This is being piloted in Morogoro and Singida region, Rungwe district plans to use basket funding earmarked for community interventions to refund transport costs when TBAs refer pregnant women to deliver at a health facility.

The reported institutional maternal mortality ratio remained stable over the last three years at around 160 per 100,000 live births (MTR-AR 2013). This could indicate that the quality of care provided at the referral facility is not adequate and or delayed referral, as a result of the various constraints faced by the women and also at the facility level as explained above. The facility based case fatality rate (CFR) is an indicator of quality of care in the management of life threatening obstetric complications- as proposed by UN- however the current HMIS does not collect data to enable calculation of CFR for obstetric complications

3.1.3 Post Natal Care (PNC)

Postnatal care services are slowly increasing. According to the TDHS 2004/05 only 13.4% of women received postnatal care within two days for the most recent childbirth. Five years later the proportion had more than doubled to 30.8%, a major increase but yet still far from universal coverage (TDHS 2010). Coverage of postnatal care was only as low as 37% among urban women and 22% among rural women (MTR-AR2013).

In an ongoing recently launched program (in Morogoro region), which is a model of an integrated facility/ community based MNCH care, the emphasis is on integrating quality postnatal care using trained CHW. They take care of postnatal care of the woman and neonate, promotion of positive behaviour, including exclusive breastfeeding, prevention of mother to child transmission of HIV, family planning, nutrition, community neonatal IMCI. Positive lessons learned during the implementation of this integrated model will be replicated in other regions and districts. The MOHSW- RCH section has

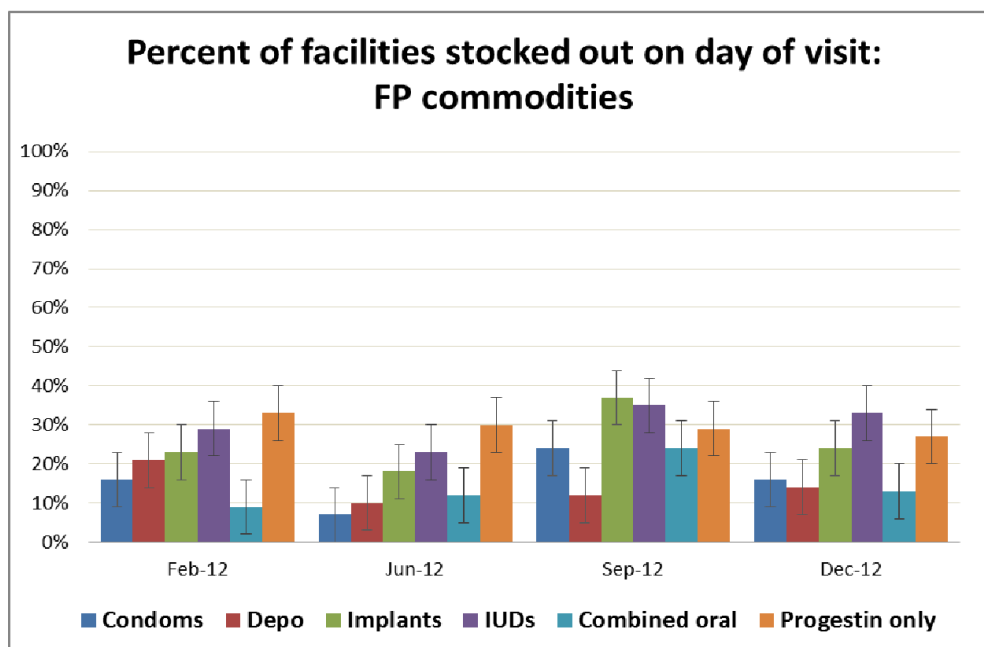
developed postnatal care guidelines and a postnatal care training package. To date these have been disseminated through training to providers in Morogoro, Iringa and Mtwara regions

3.1.4 Family Planning

In Tanzania only 27% of the currently married women use a modern method of family planning, and the unmet need for FP stands at 25% (MTR-AR 2013). The injectable and the pill are the most commonly used methods. The use of modern FP varies by residence and region: 34 % of women in urban areas, compared to 25 % of women in rural areas, use a modern method of FP. Of concern is also a large gap between the poorest and the best-off women, the education versus uneducated as well as by geographical zone in the fertility and the use of contraception. Contraceptive use among the highest educated women was 23% and 51% among women in the lowest and highest wealth quintile respectively. Geographically the Contraceptive Prevalence Rate ranged from 65% in Kilimanjaro region to 12% in Mara region. Women in the rural areas had 2.4 more children compared to women in the urban areas, with a total fertility rate (TFR) at 6.1 versus 3.7. Even though FP use for all methods has increased (from 20% in 2004/05 to 34% during 2009/2010 TDHS 2005, 2010), this rate of increase is inadequate toward achieving the "One plan" target of 60% CPR by 2015.

There are a number of challenges in the provision of FP services mentioned by respondents in the MTR: in public health services there are inadequate trained human resources with the knowledge and skills to provide FP services; there are frequent stock-outs of FP commodities, especially the injectables and implants. During field visits it was noted that NGO staffs are placing long-term contraceptives at health facilities, with minimal skills transfer to the public health workers. Similar findings were also noted by the End Use Verification study, which noted that though the availability of FP products was slightly better than essential medicines, challenges existed. The availability of various contraceptives is shown in figure 5 below (MOHSW 2013). The MTR field visits in Mbeya region noted stock outs of injectable contraceptives. Some stakeholders feel that at national level there are no problems regarding availability of FP commodities making them believe that it is the weakness of the distribution systems causing these stock outs.

Figure 5 Stock-outs of FP commodities



Source: End Use Verification Survey

It is estimated that 80% of FP services in public sector health facilities are provided in collaboration with NGO partners like Engender health, PSI etc. The MTR field visits noted unavailability of injectable contraceptive Depo Provera. Recent large scale surveys of 13 districts by NIMRI (2009) and 27 districts by Ifakara Health Institute (2012) to determine FP service readiness, showed that the proportion of facilities providing FP was 77 % and 75 % respectively, while trained staff (with guidelines) stood at 42% and 56%.

Outreach services for FP seem to be inadequate due to inadequate human resource and transport at district level. This was confirmed in almost every field site visited during the MTR. In one district visited (Bukombe) there was adequate partner support to provide training, commodity supplies, outreach services and community mobilisation, including the training of community based FP distributors. The district data shows that the contraceptive acceptance increased from 3% in 2010 to 23% in 2012.

Other challenges in FP include: spousal refusal, and clients' general misconception FP use, and provider poor attitudes towards clients, including refusing to counsel clients on some of the long-term methods such as IUCD.

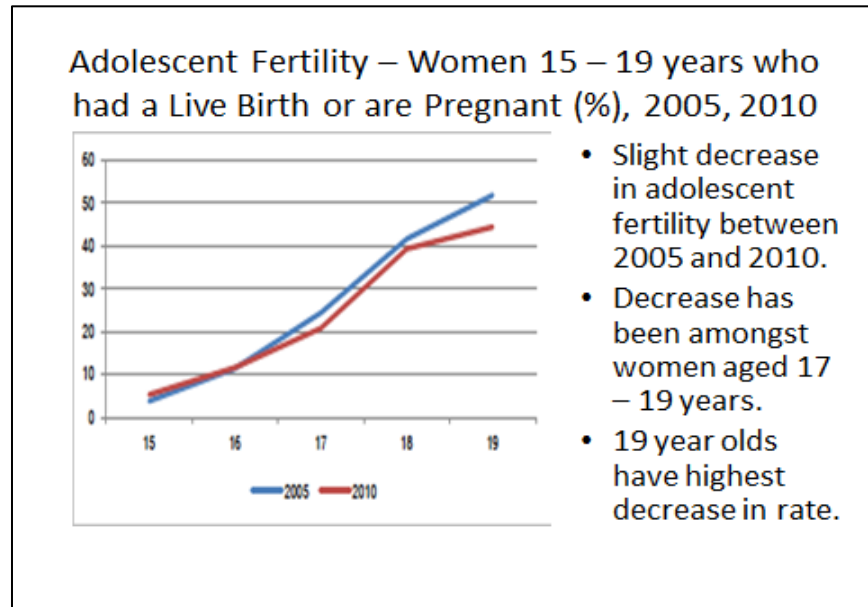
The MOHSW- RCH section in partnership with key Development Partners developed the National FP Costed Implementation Program Strategy (NFPCIP). The program aims to reposition FP in the national agenda and achieve the target of 60% CPR. The NFPCIP targets renewed advocacy on FP and adequate funding for program implementation. The other strategies for the NFPCIP include: contraceptive commodities and logistics, capacity building, improved service delivery, and health system management. According to the FP coordinator implementation efforts will be directed to zones with low CPR, such as the Lake Zone and Western zone. The reposition of family planning has also benefited from the high level political commitment by his excellence President J Kikwete. When he attended the London FP summit in July 2012, he committed the government to achieving a 60% CPR by 2015. This should be followed up with advocacy to increase national budget for FP.

Adolescent Reproductive Health

Adolescent constitute 31% of the total population (TDHS 2010). Sexual and reproductive health risks for the adolescents and young people include: early marriages and underage pregnancies, unprotected sexual activities exposing young women to the risk of STI/HIV, unintended pregnancies, unwanted childbearing and unsafe abortions.

In Tanzania teenage pregnancy is high: according to TDHS 2010 23% of women aged 15-19 years are pregnant or already have children; this is a slight decrease from 26% in 2004/5. Teenage pregnancy and motherhood are more common among young women living in rural areas and those from poor families. Only 16% of young women aged 15-24 uses of modern methods of FP (in rural areas 15% versus 20% in urban areas). Sixteen percent of currently married young women aged 15-19 and 24% of those aged 20-25 has an unmet FP. Despite exposure to FP messages, only 9% of women 15-19 years, who were not using contraception, discussed FP with a health provider in a health facility in the year before the survey.

Figure 6 Adolescent fertility



Source: MTR-AR 2013

Youth and Adolescent Sexual and Reproductive Health (ASRH) is a priority. The MoHSW has developed an adolescent sexual and reproductive health strategy, and standards and guidelines for Adolescent friendly sexual and reproductive health (AFSRH) services.

According to the MOHSW, despite the availability of policies and guidelines, the provision of friendly services to adolescents seems not to have taken off at most public health facilities. For example during the field visits for MTR, none of the districts visited provided AFSRH services. During discussions, staff seemed not to be aware of the strategy. An exception was Ileje district, where at Ibaba health centre a local NGO offers RH services to youth. But these do not meet the standards of ASRH. Most of the youth coming to the health centre were already pregnant and seeking ANC. Stakeholders indicated that there are some NGOs, such as AMREF, currently engaged with adolescents, but mainly with regards to HIV prevention and while other RH services are not covered.

At MOHSW level the MTR team was informed that in some regions AFSRHs are available with support from partners, for example in Iringa Morogoro, Tanga and Pwani, Pwani and Dar es Salaam, but again no data was available.

The 2012 SARA reports that 44% of the facilities surveyed had readiness for adolescent service provision. However, the readiness was only with regards to HIV counselling and testing and provision of condoms, excluding provision of other FP services (SARA 2012). The Road map target to increase the number of health facilities providing AFSRH services to 80% is unlikely to be met. Moreover there is no baseline data regarding this target.

3.2 Neonatal Health

Neonatal Mortality

Neonatal mortality, covers deaths in the first month after birth, the major causes of neonatal deaths generally differ from those of post-neonatal. The main causes of newborn mortality in Tanzania are infections (29%), asphyxia (27%) and prematurity (23%) (MOHSW 2009). Child survival continued to improve throughout the period 2000-2011 and appears to be on-track to meet the MDG target in 2015. As a result of the basic health services extension policy and massive expansion of immunization, as well as prevention of malaria and treatment of fever in children, the health status of children in Tanzania has improved considerably. This is shown by the drop in infant mortality rate from 162 per 1,000 live births in the 60s to the current 51 per 1,000 (MTR AR 2013).

While significant progress has been made to reduce child mortality in Tanzania, the neonatal mortality rate remains high at 26 per 1,000 live births. It accounts for slightly over half of the infant mortality rate and a third of child mortality (MTR-AR 2013). This means that neonatal mortality is moderately declining. Furthermore the disparities between the urban and rural children and between the poorest and better off have reduced considerably and are small at present. However the Northern region has the lowest neonatal mortality (MTR-AR 2013). Not all facilities have the necessary essential neonatal equipment available: only 21% has a neonatal bag and mask and 35% has a suction apparatus. The target of the "One Plan" is to have increased proportion of health facilities offering essential newborn care to up to 75%.

Neonatal care

In 2009 Tanzania did a situation analysis of newborn health outlining the current situation, existing plans and strategic next steps for newborn health. Among other things, it singled out three key interventions to address key causes of neonatal deaths. These include Integrated Management of Childhood Illness (IMCI), Helping Babies Breathe (HBB) and Kangaroo Mother Care (KMC). Helping Babies Breathe (HBB) is a strategy MOHSW established in September 2009 to address birth asphyxia. The Kangaroo Mother Care program was initiated in 2007, and is currently implemented in 31 health facilities in regions and some district where mothers are taught the 'Kangaroo Mother Care' technique, which helps to keep a low birth weight baby warm. Furthermore HBB training has been rolled out to the regions and districts, including the training of Zonal/District HBB trainers. Country wide over 5,248 providers have been trained on HBB and are encouraged to do on the job training of other providers.

The health sector is facing shortage of human resources and equipment. Some regions only have one paediatrician. In Mbeya Regional Referral Hospital the only specialist available in the hospital is a paediatrician. Despite the roll-out of IMCI in Mbeya region, quite a few health providers in were not conversant with this approach. The MAISHA programme (Plotkin et al. 2012) noted that lower level health facilities were very poorly equipped for newborn resuscitation at baseline, but showed dramatic improvements by the end of the intervention.

The target of the one plan is to have increased proportion of health facilities offering essential newborn care to up to 75 %.

Exclusive breastfeeding

Only 50 % of infants under 6 months are exclusively breastfed in Tanzania, though this is an improvement, compared with the 2004-05 TDHS (41 %), see table 2 on the trends of EBF.

Table 2 Trends in exclusive breastfeeding

Period	Age of Child in Months				
	0-1 months	2-3 months	4-5 months	6-7 months	< 6 months
1996	55.2 %	27.4 %	8.0 %	4.1 %	28.9 %
1999	57.8 %	25.4 %	15.5 %	1.9 %	No data
2004/2005	70.0 %	42.4 %	13.5 %	1.7 %	41.3 %
2010	80.5 %	51.1 %	22.9 %	2.3 %	49.8 %

Source: Tanzania Food and Nutrition Centre Tanzania Assessment for Scaling Up Nutrition 2012

Children whose mothers were assisted during childbirth by a TBA and non-health professional are most likely to receive prelacteal feeds (37% and 40%, respectively), while children whose mothers were assisted by a health professional are least likely to receive prelacteal feeds (24%). The practice of prelacteal feeding decreases as wealth quintile increases. In Mara 55% of children received prelacteal feeds compared with only 2% of children in Iringa. More than 30% of children of mothers in the lowest wealth quintile receive prelacteal feeds, compared with fewer than 30% children of mothers in the highest wealth quintile (TDHS 2010).

WHO recommends breastfeeding within one hour of birth. 94% (2010) infants were breastfed within 24 hours after birth compared to 92 % in 2004-05, which is a modest increase. However there is also considerable variations by regions; by location (urban versus rural areas); by type of person who assisted at delivery; and by wealth quintile. Early initiation of breastfeeding was more common in urban areas (62%) than in rural areas (45%). Less than 30% of children were breastfed within one hour after birth in Singida, Rukwa, Mwanza, and Mara. It was highest in Manyara and Arusha regions (93 and 83 %, respectively) (TDHS2010).

Apart from benefits of EBF in improving nutrition in infants, EBF need to be promoted more considering its role in reducing HIV transmission in infants. A WHO led randomised controlled study in Burkina Faso, Kenya, and South Africa in 2011 found that a combination of ARVs during pregnancy, delivery and breastfeeding reduced the risk of HIV transmission to infants by 42% (Kesho Bora study 2011). Also in Malawi a nutrition and HIV study showed that a risk of HIV transmission reduced to just 1.8% when EBF was combined with ARV treatment Triple ARV compared with zidovudine and single-dose nevirapine prophylaxis during pregnancy and breastfeeding for prevention of mother-to-child transmission of HIV "C.Chasela, et al 2010.

3.3 Child Health

Child survival continued to improve throughout the period 2000-2011 and appears to be on-track to meet the MDG target in 2015. As a result of the basic health services extension policy and massive expansion of immunization embedded in IMCI program. In Tanzania child survival interventions are being implemented simultaneously. These include several vaccines, insecticide treated mosquito nets, and nutritional interventions including micronutrient supplementation. Furthermore there is nutrition counseling (breastfeeding and complementary feeding) and growth monitoring. In addition to these preventive interventions there is the provision of oral rehydration antibiotics and antimalarials (Ramsey et al 2013). Thus the health status of children in Tanzania has improved considerably. The main causes of child mortality in the country are malaria, pneumonia, diarrhoea and HIV/AIDS (MOHSW2008). However, it should be noted that there are certain poor health indicators in children requiring urgent attention such as stunting, low infant diagnosis of HIV.

3.3.1 Vaccinations (including new vaccinations)

Access to services is good: three-quarters of facilities offered child immunization services and according to a large facility survey conducted in 2012, over 90% of those facilities had key supplies such as vaccines and needles in stock at the time of the survey (Post-campaign immunization coverage survey 2011, SARA 2012)

DTP3 coverage among children under 1 year continued to be around 90% during 2009-2012 and was slightly higher than the baseline in 2008. The DTP3 coverage among children 12-23 months old in the household surveys also indicated very high levels of coverage. Coverage of measles vaccination is also increasing and well above the target of 85%. The facility-based estimate for 2012 showed 97% coverage, up from 95 % in the preceding year. The 2011 survey suggest a post campaign increase in measles and DTP3 vaccination. Immunization coverage shows modest socioeconomic inequalities as almost all subgroups have DTP3 coverage well over 80%, except children of women with no education (79%). However MTR field visits uncovered BCG vaccine stock outs beginning in December 2012 that lasted for more than a four month period in all the three regions (Geita, Lindi and Mbeya) visited during the MTR.

Tanzania introduced two new vaccines into its immunization schedule in January 2013– pneumococcal and rotavirus vaccines, which help prevent pneumonia and diarrhoea, respectively. These two diseases are the main causes of death of children under 5, so the vaccines represent another huge step to promote child survival. In Geita Region it was uncovered during the MTR field visit that the rota virus vaccine and PCV13 vaccines are not regularly supplied, Apart from inadequate supply of vaccines there was also a shortage of syringes. As for Mbeya region there was no standby fridge as per the requirement of cold chain. Lack of transport was also affecting availability of vaccines.

The HMIS 2012 trends indicate that some regions, such as Kigoma, need special attention, while 71 % of districts have coverage rates exceeding 80 % by 2012 (MTR-AR 2013).

The national school health programme also include immunisation of school going children under the age of 7 just to ensure that BCG vaccine reaches even children who missed out on vaccination. However, the efficacy of providing BGC at such an age remains unknown.

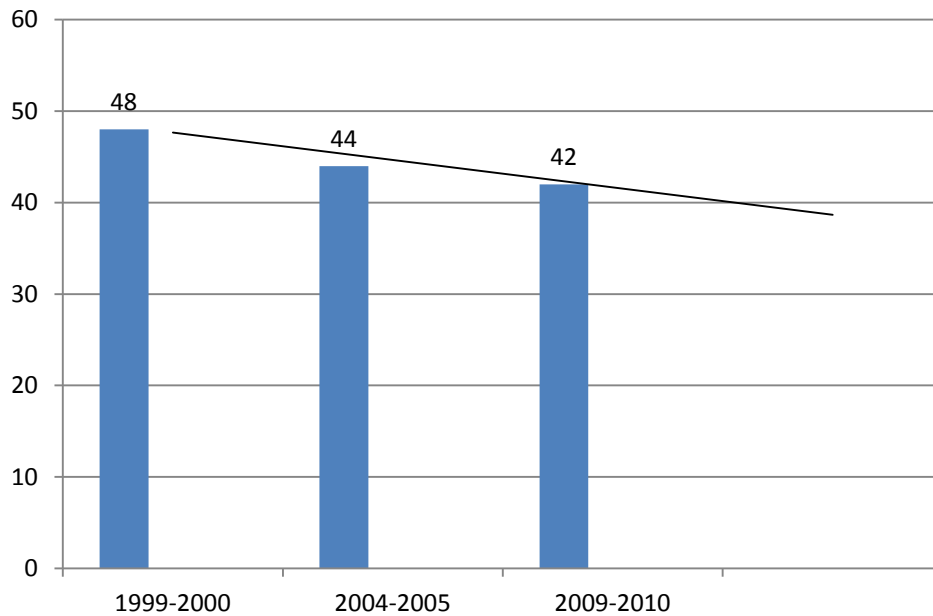
3.3.2 Anaemia and Nutrition

Nutrition

Child anthropometric indicators are improving but at a slow rate. The greatest improvement is observed in the proportion of children who are underweight (below minus 2 standard deviations of the global standard). According to the 2005 WHO reference, the prevalence of underweight has decreased from 25% in 1991 to 16% in 2010 (TDHS). Therefore the country is in a good way to reach the 2015 target of 12.5% for underweight.

In terms of chronic malnutrition, Tanzania is one of the 10 worst affected countries in the world with 42% of children aged less than five years being stunted (Vester et al. 2010). In 2014, it is estimated that more than 3.000.000 children will be affected by stunting. Children in Tanzania are at risk of malnutrition because of repeated episodes of ill health (malaria, diarrhoea, pneumonia and other illnesses) and inadequate infant and young child feeding practices. Other underlying causes include inadequate health care for women and children, insufficient health services and unhygienic environment (TFNC 2007). The proportion of children who are stunted declined slower than the proportion of underweight. Over a 10-year period, prevalence of stunting declined from 48% to 42%. To reach the 2015 target of 25% stunting, it will be necessary to develop a multisectoral approach focusing on the 1,000 days window of opportunity between conception to 2 years.

Figure 7 Trends in stunting in children



Children in rural areas were more likely to be stunted (45 %) than those in urban areas (32%), and a similar pattern is noted for severe stunting (18 % for rural and 12 % for urban areas). Disparities were also noted across regional s, four regions have levels of stunting that exceeded the 42 %. Dodoma (56 %), Lindi (54 %), Iringa (52 %) and Rukwa (50 %). Children of mothers with at least some secondary education had the lowest stunting levels (22 %) compared to mothers with no education or only with an incomplete primary education stunting levels were 40 % and 49 % respectively. Stunting also varied by wealth quintile the lowest household wealth quintile had a stunting level of 48 % compared to a 26 % stunting level among children from the highest wealth quintile (TDHS 2010)

In terms of acute malnutrition, the prevalence of global acute malnutrition has decreased from 8% in 1991 to 3.5% in 2005. However in 2010, the level has been increased up to 5% in 2010, including 1.3% of severe acute malnutrition forms. The expected caseload in 2014 is more than 220.000 severely acute malnourished children and more than 380.000 moderately acute malnourished children (Vester et al. 2010).

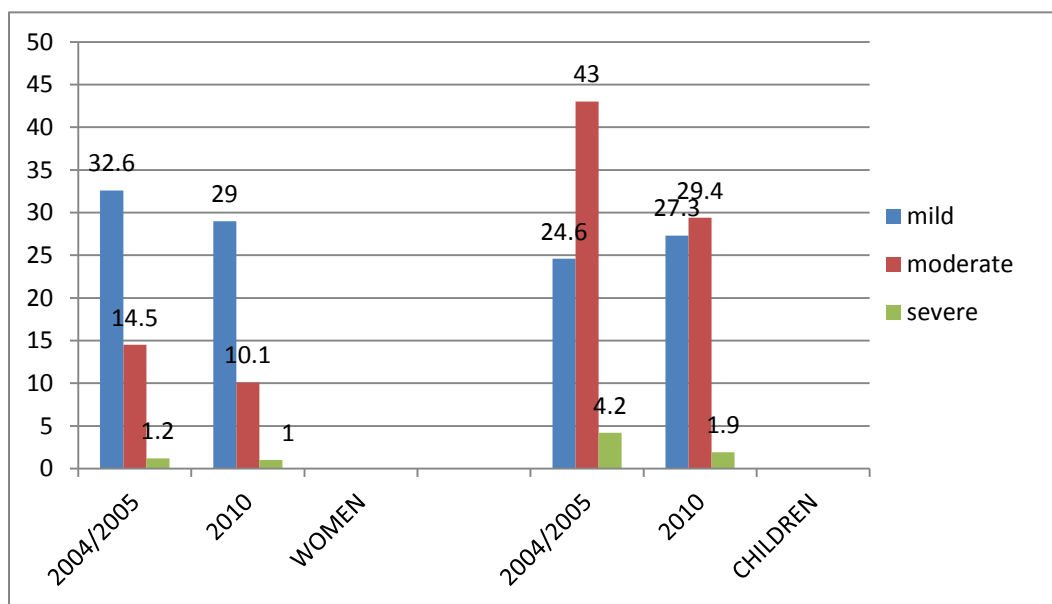
Anaemia

The prevalence of anaemia in children under 5 dropped by 18 % in the past five years, from 72 % to 59 % (THDS 2010). Tanzania has put in place a number of interventions to address anaemia in children. These include deworming of children aged 2 to 5 years every six months and promotion of use of insecticide-treated mosquito nets (ITNs) by children under age 5. Periodically children aged 6 to 59 months are given Vitamin A supplements. Vitamin A supplementation (VAS) was integrated with deworming program a few years after its inception, which helped to improve its coverage. Other measures to improve nutrition status of children include food fortification, by Micronutrient Powders (MNPs) targeting children aged 6 to 23 months and children aged 6 to 59 months. These MNPs contain 10 vitamins and 5 minerals (15 micronutrients in total).

According to the Micronutrients study results of the 2010 Tanzania Demographic and Health Survey, 35% of children had iron deficiency, and 59% had anaemia. The overall prevalence of iron deficiency anaemia (IDA) among children was 24%, while the rate of iron deficiency without anaemia was 11%.

While anaemia prevalence has been reducing in Tanzania, the prevalence is still high. See the figure below for the trends.

Figure 8 trends in anaemia of women and children



3.3.3 Vitamin A

A long-term objective of Vitamin A program in Tanzania is to reduce Vitamin A Deficiency (VAD) and its consequences to levels where they are no longer of public health significance. Prevalence of VAD in children below 5 years was 24% in the National Vitamin A Survey of 1997 (measuring serum retinol levels) and in 2010 it was 34 % (Retinol Binding Protein (RBP). Vitamin A supplementation (VAS) was integrated with de-worming program a few years after its inception (TAFNAC 2012). Although, there has been evidence of improvements in VAS coverage, there exist inconsistencies in the data sources (Nyhus Dhillon 2013). This data inconsistency has prompted the Tanzania Food and Nutrition Centre (TFNC) and Hellen Keller International (HKI) to conduct data audit exercise to shed the light about the possible sources of such discrepancies. A discrepancy of 30 percentage points was found between the preschool VAS coverage and the administrative data from the regions. The Demographic and Health Surveys (TDHS2010) found that average coverage over the June and December 2010 rounds were 59.8%.

Other measures to improve nutrition status of children include food fortification, whereby Tanzania has two programs on Micronutrient powders (MNPs) targeting children aged 6 to 23 months and children aged 6 to 59 months coordinated by MOHSW through TFNC; and Tuboreshe Chakula under USAID, respectively.

Both programs use MNPs containing 10 vitamins and 5 minerals (15 micronutrients in total). There is a guide on micronutrient composition levels, how to fortify complementary food at home, and frequency of intake of the MNPs. Tanzania developed its own national guidelines for the MNP program.

Tuboreshe Chakula has already started implementation of MNP though its coverage is still low because in three regions where this program is initiated not all the regions are covered.

MOHSW is in the final stages of preparations to support a similar program. Meanwhile the national Food Fortification Program under TFNC has contracted suppliers of MNPs.

The Minister, of MOHSW had participated and adopted the ECSA/HMC46/R10 resolution which amongst other items urges Member States, to (1.) adopt and support implementation of ECSA food fortification guidelines by end of 2009 and

(2). allocate/increase financial resources by at least 20% for nutrition with a focus on micronutrients interventions such as Vitamin A supplementation, iron and folic acid supplementation, fortification and other food-based interventions in health budget/basket funds (Vester et al. 2010).

His Excellency, President Kikwete of Tanzania, is committed to improving the nutritional status of the population and on 15 and 16 May, 2013 was among the delegation on the launch of the country's food fortification program and the Presidential Call to Action for Nutrition.

The Global Alliance for Improved Nutrition (GAIN) has contributed over US\$ 600,000 to support a large-scale food fortification efforts in partnership with Helen Keller International, DFID and the Tanzania Food and Nutrition Centre in Tanzania. (Global Alliance for Improved Nutrition 2012 Tanzania food fortification launch). GAIN's support to nutrition interventions in Tanzania is through working with GOT under the Scaling Up Nutrition (SUN) Movement (Vester et al. 2010). The major millers and food processors in Tanzania have committed to fortifying wheat flour, maize flour and oil. The private industry is the main implementer of the programme, which will cover the recurrent cost of the actual fortification in the future, once the initial cost of fortificants has been covered. DFID is providing approximately 8.4% of the entire programme costs (which will translate to 243,600 women and 184,800 children under 5 consuming fortified flour, and 478,800 women and 361,200 children under 5 consuming fortified oil) (Claeyssens et al. 2013)

Malaria prevention ITN and treatment

Malaria is a leading cause of child mortality. The evidence suggests that malaria mortality and morbidity in Tanzania mainland have declined during HSSP III, and probably also before 2008. Health facility data are also suggestive of a reduction in malaria morbidity and mortality. National parasitemia rates by Rapid Diagnostic Tests (RDT) have halved to 9 % in the period 2007/08 -2011/12 (RBM2012). There are equity issues regarding who is affected most by malaria: the poor are most affected than the best-off. Tanzania HIV & Malaria Indicator Survey reports that Malaria prevalence is much higher in rural areas (5%) than in urban areas (1%). Among zones, malaria prevalence is highest in Lake and Western zones. Malaria prevalence is highest along the coast, in the southern lowlands, and in regions bordering Lake Victoria (RBM2013). Malaria prevalence decreases, in general, with the mother's education level and with increasing levels of household wealth (TACAIDS 2013). Recent information suggests a prevalence parasitaemia of 9.2% in 2011/12 bringing it close to the 2015 target of 5% (MTR-AR 2013).

Insecticide Treated Net (ITN) use increased dramatically: three quarters of children and pregnant women used ITN, a threefold increase during 2007/08-2011/12 and is close to the 2015 target. 18,562 571 ITNs were distributed between 2007 and 2010 through mass campaigns and the national voucher scheme (RBM2012).

ITN utilisation did not vary much by a child's sex or urban-rural residence. Variations in ITN use by children under 5 varied by region and wealth (Tanzania HIV and Malaria Indicator Surveys 2011-12). Lindi (87%) followed by Pwani (84%) and then KIGOMA (80%) had the highest ITN use above the national average of 72%. Surprisingly Dar es Salaam (63%) in mainland had the lowest ITN use followed by Mbeya (65%) and then Rukwa and Arusha both at (67%) were among the regions with lower ITN use among under 5s. The lowest wealth quintile had a lower ITN use (71%), similar to that for the highest wealth quintile (71%) this could possibly mean that the subsidized ITN scheme might have increased ITN access and use among the poor. Tanzania HIV and Malaria Indicator Surveys 2011-12 show that the middle wealth quintile had the highest ITN use at 75% (TACAIDS 2013).

The use of ACT in children with fever in the last 2 weeks preceding the survey increased from 24 % to 33 %, while ACT availability in clinics remained at 80 % according to the facility surveys. The availability of malaria RDT more than doubled from 30 % to 75 % of health facilities. (MTR-AR 2013.) Among children with fever, (77 %) sought treatment from a health facility, provider, or pharmacy, and (25 %) had blood taken from a finger or heel for testing. Treatment-seeking behaviour is more common among children less than 12 months old and children of women with secondary education or higher.

Treatment-seeking behaviour also increases with household wealth. The percentage of children with fever for whom advice or treatment was sought differed little by urban-rural residence (81% and 77%, respectively), the proportion of children with fever who had blood taken for testing is much greater in urban areas (61%) than rural areas (17%) indicating a huge inequality in accessing diagnostics between urban and rural areas. Regarding actual treatment sought, 54% of children under age 5 with fever in the two weeks preceding the survey took some type of antimalarial drug, and 33% took ACT the same day or the next day after getting the fever, while (21%) were given ACT the same or next day following the onset of fever (TACAIDS 2013).

The proportion of children with fever who were given antimalarial drugs is slightly higher among children in urban areas (59 %) than those in rural areas (53 %) and among those in the highest wealth quintile (60 %) compared with those in the other wealth quintiles (51-54 %); however, children from rural areas (34 %) and those from the lowest wealth quintile (40 %) were more likely to have received ACT than those from urban areas (26%) and those in the highest wealth quintile (28 %).(TACAIDS 2013)

Table 3 Summary: Targets and Current Achievement for the One Plan

Indicator	Baseline	Target	Achievements to date by 2012	Status / Comment
Child mortality under 5 years per 1,000 live births	91 for 2003-2007 (THMIS 2007/08)	79/1000 (2010) 54/1000 (2015)	81 for 2006-2010 (TDHS)	Improving, close to target but not on MDG pace (baseline revised based on new data)
Neonatal mortality per 1,000 live births	32 (per 1,000 live births)	19 (per 1,000 live births)	26/1,000	Slightly improving needs more attention if target is to be reached
Infant mortality	80/1,000		51/1,000	Improving
Maternal deaths in facilities	160/100,000		161/100,000	Stable, not decreasing , this could indicate poor quality of care in health facilities
maternal mortality per 100,000 live births	578/ 100,000	193/100,000 (2015)	454//100,000 (2010)	Slightly improving but not on MDG pace need more attention
coverage of births attended by skilled attendants	46%	80%	51%(2010)	Slightly improving but need more attention to meet target
coverage immunization of DTP-HB 3 and Measles vaccine		above 90% in 90% of the districts	*Variations per vaccine	Improving enough to meet the 90%. however there are vaccine stockouts >4mths needing some attention
New EPI vaccines introduced (Hib, Pneumococcal, Human Papilloma Virus (HPV) and Rota	New vaccines not introduced		Introduction of New EPI vaccines	Introduced in most facilities but challenges include stockouts irregularity in supply of new vaccines

Indicator	Baseline	Target	Achievements to date by 2012	Status / Comment
Prevalence of malaria parasitemia (under 5 years)	18% (2008 THMIS)	10% by 2010; 5% by 2015	9.2% by RDT in 2011/12	Close to target: major reduction
Reduced stunting and underweight status among under-fives from 38% and 22% to 22% and 14%, respectively.		Reduce stunting to 22% underweight to 14%	14% target met for underweight NPS2011 Stunting at 42% than baseline	Stunting increasing slightly than baseline; substantial reduction in underweight target for reducing underweight met
Increased exclusive breast feeding coverage from 41%	41%	80%	50%	Increasing but not at enough pace to reach the 80% target
PMTCT services provided to at least 80% of pregnant women, their babies and families.	-	77% for pregnant women 22% for babies	at least 80% of pregnant women, their babies & families.	Likely to meet target for pregnant women need more effort for babies, stockout of Nevirapine for babies is a threat to reaching target for babies
Increased coverage of under-fives sleeping under ITNs from 47% to 80%.	<5 yrs: 26% PW: 27% (2008 THMIS)	60% by 2010 80% by 2015	73% (children) 76% (pregnant women)	Both indicators are ahead of 2015 target schedule
Increased modern contraceptive prevalence rate from	From 20% to 60%		34%(2010)	Increasing but need more attention the most preferred contraceptive injectables were out of stock in some regions
Increased coverage of CEmOC from 64% of hospitals to 100% and of BEmOC from 5% of health centres and dispensaries to 70%	BEmOC from 5% of HC & dispensaries to 70%		64 % of facilities offered normal delivery services only 25 % offered all components of BEmONC, (20% of dispensaries and 39% of HC). CEmONC in 73% of Hospitals	Pending data for CEmOC coverage in health centres. Significant increase in facilities offering BEmOC likely to meet the 70% target is more attention is given
Increased ANC attendance for at least 4 visits	from 64% to 90%		36%	Decreasing from 64% in 2004/2005 unlikely to meet target need huge efforts
Increased proportion of health facilities offering Essential Newborn Care to.	-	75%	Pending data	

Indicator	Baseline	Target	Achievements to date by 2012	Status / Comment
Proportion of laboratory confirmed malaria cases among	-	-	-	No data, clinical malaria can be used as proxy
Proportion of mothers who received 2 doses of IPT for malaria during last pregnancy	the one plan used the 2010 THMIS d that was at 30% as baseline	60% by 2012	31% (THMIS	Limited progress, not at pace to meet target
doses of IPT for malaria during last				

*In 2010, 75 % of children aged 12-23 months were fully immunised, representing a modest increase relative to the proportion reported in the 2004-05 TDHS (71 %) and the 1999 TRCHS (68 %). 90 % of children received BCG, DPT/DPT-HB 1 and 2 (or DPT-HB-Hib 1 and 2), and Polio 1 and 2. However, the proportion of children receiving the third dose of DPT/DPT-HB (or DPT-HB-Hib) and polio vaccine is lower (88 and 85 %, respectively), so is the proportion receiving measles vaccine (85 %). The decrease in vaccination coverage between the first and third doses of DPT/DPT-HB/DPT-HB-Hib and polio are 8 and 12 %age points, respectively. Only 3 % of children have not received any vaccinations at all. With the exception of measles, more than 80 % of the vaccinations were received by 12 months of age, as recommended. Overall, 66 % of children were fully vaccinated at 12 months, a small increase from that reported in the 2004-05 TDHS (62 %).

3.3.4 School health

The School Health policy guidelines and the strategic plan are currently under review by MOHSW and MoE. School health assessment helps children to maintain basic levels of health, so that they can consistently attend school. Other components of the school programme are birth registration to ensure that the children are legally recognized, training to empower children with knowledge of their rights.

The existing health education curriculum was integrated into the school curricula. Teachers provide health education as part of regular subjects and to deliver school first aid, provide deworming drugs, guidance. School Health Coordinators from Health and Education exist at all levels national, regional, district, ward and school levels. A team of local health workers assisted by teachers conduct physical health checks in schools and record health status in pupil health card. Pupils are referred to health facilities if need arises for health management. Pupils are screened for vaccination (BCG & TTV), their anthropometric measurements (age, weight) and for other diseases (skin diseases, blood pressure, goiter, liver/spleen enlargement, physical deformities, mental problems, tuberculosis, heart problems, anaemia, diabetes, schistosomiasis, soil-transmitted helminths). There is also a School Water and Sanitation program to promote school hygiene and sanitation, which covers many schools. School meals provision is being done under MoE policy though not all schools receive meals.

A number of NGOs are also active in school health related activities. In Arush an NGO known as World Education Inc. (WEI), involved 29 districts in executing a five-year initiative of the US President's Emergency Plan for Aids Relief (PEPFAR) which is supporting GOT in implementing the most vulnerable coordinated care programme, 'Let's raise them together. Under this programme school children are screened for common diseases. Other NGOs involved in the PEPFAR initiative are Africare (Central zone), Pact (Lake Zone) and Family Health International -FHI- (Coastal zone). CIDA through the pooled funding provides funds to the GoT - National Multi-sectoral Strategic Framework Grant (NMSF) under which teachers are trained in Life Skills education for HIV/AIDS prevention this is a national programme.

The School Eye Health program aims to address the challenge of avoidable blindness in children, after the successful completion of the pilot phase, which ran from January 2012 until March 2012 when 15 teachers from five schools in the Bagamoyo District were trained: they eventually screened the eyes of

3564 children, referring 146 to the vision centres supported by the Brien Holden Vision Institute. Through the project 90 – 100% of the children at all five schools were screened (extract from interview provided by the National Eye Health Coordinator, Dr Mwakya).

However, community involvement and participation in supporting school health programs is limited, though it involves multisectoral collaboration. The follow up in the community with the referral including with the caregivers of the children and feedback to the schools still remains a challenge. School health programme provides a good opportunity to improve adolescent RCH (especially prevention of teenage pregnancy, provision of contraceptive by youth themselves to fellow youth such as having quality trained youth CBDAs, youth HIV/AIDS counsellors)

3.4 Crosscutting issues

3.4.1 Improving Quality

Guidelines and Standard Operation Procedures (relate to TQIF)

One of the One Plan Roadmap strategies is to develop user-friendly protocols and guidelines. To a large extent this strategy has been implemented. The MOHSW –RCH section has developed several relevant guidelines and standards and practice protocols, for each component program. Just a few are listed: FANC guidelines, BEmONC training guide, Guidelines on Maternal Death and Perinatal Death Reviews, Postnatal Care guidelines and guidelines for integrated community maternal and child health, PMCTC guideline, Emergency Obstetrics Job AIDs, IMCI guidelines, Guidelines on management of GBV, Guidelines on integration etc. During MTR field visits the team found that most of these standards were not available particularly to health providers, and they were not aware of them. The most commonly available standard was the standard management of Sexually Transmitted Diseases and provision of ART.

Maternal Death Reviews and Notification

A good practice that the MTR team observed in some of the districts visited is the maternal death (MD) review. The MTR team was informed that every MD and perinatal death review that occurs is reviewed within five days of its occurrence. The HMT under the supervision of a CHMT member (usually DMO or DRCHCO) undertakes the review according to guidelines provided with an objective to identify the cause of death and whether it was avoidable and or preventable. Action is taken depending on the level of prevention identified including feedback to the community. The duly filled forms are submitted to the MOHSW -RCH section. However the MTR team was informed that these forms have never been analysed and the districts do not get any feedback, and it was also unclear as to the completeness of MD documentation in the hospital and the extent of facility compliance to MD reviews and notification..

Capacity building (pre-service and in-service training)

MOHSW embarked on in-service training programme of providers on Focused Antenatal Care (FANC) on Life Saving Skills (LSS) for Emergency Obstetric Care, including development a curriculum for basic and advanced LSS, later changed to BEmONC training with support from MNCH partners. The Curriculum and training guides are in place. The USAID supported MAISHA implemented by MOHSW and JHPIEGO has been conducting the training in the regions and districts where MAISHA is operating- (which included regional hospitals and at two districts in each region - two to three HC/Dispensary per district). This included trainee follow up and supportive supervision, and provision of some BEmONC equipment to health facilities. Availability of a standard national Curriculum on FANC and BEmONC has enabled other partners e.g. USAID funded NGOs and Canadian government funded partners , UN partners etc, to scaling up BEmONC training at several regions and facilities as stated above. However, in some of the facilities visited during the MTR field visits, in addition to shortage of skilled personnel,

some of those health workers met have not been trained on FANC and BEmONC, a situation observed in facilities visited in Geita and Bukombe districts, as well as in Lindi district. Furthermore most of these trainings had been organized centrally. There is inadequate capacity at regional/district level to conduct trainings and follow trainees, and/or conduct supportive supervision. According to the Tanzania Service Availability Readiness report of 2012, only 20% of facilities surveyed had at least one staff, who had been trained in integrated management of pregnancy and childbirth, and 58% had staff trained on ANC (SARA 2012).

A recent large survey of practicing nurses and midwives showed that they had major gaps in knowledge and midwifery skills and competencies and that study none of the participants reached the standard score to be accredited as a competent midwife (Leshabari et al. 2010). Several other studies have also reported poor technical quality of MNCH care provided in health facilities, including poor client communication skills (Mselle et. al 2011, Plotkin et al 2010). Trainees require follow up to ensure they practice the skills imparted, as well as learn on the job training and clinical mentoring of new staff. Although the CHMT has been trained on supportive supervision, there is limited capacity to conduct clinical mentoring at district level. The MOHSW is currently developing guidelines on clinical mentoring. Other trainings conducted include training of health workers on delivery of quality nutrition services to women and children undertaken by Mwanzo Bora Nutrition program in Dodoma, Morogoro and Manyara regions.

In conclusion, there is a lot of training and capacity building going on in the country, but still insufficient to reach every health worker in every corner of the country. Knowledge and skills in practice are still insufficient.

Supervision and Mentorship

The MOHSW-RCH is responsible for health policy, practice standards protocols as well as supervision through RHMTs of implementation of RH and MNCH services. At Regional level there is a regional RCH coordinator who together with the Regional Health Management Team (RHMT) performs the functions, including supervision of the HMT and CHMTs of all districts in the respective region. However the RRCHCO is only a co-opted member of the RHMT. At the Zonal level a Zonal RCHCO is taking care of several regions, but it is not clear if they have a supervisory role on behalf of MOHSW to the RHMT. RHMT members are usually trained on supportive supervision and the MOHSW has developed a comprehensive supportive supervision guide. Until recently there hasn't been a formal orientation of RCHCOs on their expected roles. However, a formal training package has been developed specifically targeting new RCHCOs (who are less than one year in their post) and the first training took place during the course of July 2013.

Stakeholders mentioned that there is currently no framework for mentorship, coupled with lack of supportive supervision. On health worker mentioned: "I was employed 3 years ago; once they dropped me here (at the duty station) they have never visited me." At present attempts are being made to look at how mentorship can be done better. It was also reported that at times the RHMTs feel disempowered to act on issues because the central ministry level directly deals with the districts. This creates a situation where the districts tend to act on the issues raised by the central level and not act on issues raised by the Region.

At district level there is a district RCH coordinator, who is also a co-opted member of the CHMT. The CHMT is supposed to provide supportive supervision to the district hospital management team as well as to all facilities under the districts. There is no training for the DRCHCO, even though they also have had supportive supervision. Supervision is now compartmentalised per subgroup of MNCH. Currently there is a tool under development to enable integrated supportive supervision where FP, ANC, PNC PMTCT are assessed together.

3.4.2 Infrastructure (labour rooms, theatres), Equipment and Supplies

Equipment and supplies

Constraints in the provision of MNCH services, observed at the districts visited, were inadequate facilities and equipment to conduct a normal delivery, medicines and supplies (MgSO₄, oxytocin, antibiotics, disinfectants, proper beds and linen, plastic mattress covers cotton wool, gloves and syringes). The MTR team noted infrastructural limitations such as limited labour room space, lack of running water, and no light source, making the 24 hr availability of maternity services a challenge. This situation exists in spite of the findings of a recent MOHSW report on rapid assessment of EmONC equipment availability and gaps in public and FBO health facilities in all regions and 127 districts conducted in 2011. According to this report, 87.8% of the surveyed facilities had received equipment from the MOHSW or from MNCH partners, and that the equipment gap was less than 25%. However it was also reported that the facilities had a poor inventory system, and there was no existing system for replacement/repair of broken equipment in 72% of the facilities. Only in 46 % of facilities providers had not been trained on proper use of equipment (MOHSW 2011). During the MTR field visits a common complaint by health providers and by CHMT members was that some of the equipment supplies was of poor quality, and examples given included scissors, and BP machines etc, that easily broke after a short duration of use.

At the district hospitals visited, the theatres were functioning, but they had problems with availability of anaesthetists and equipment for anaesthesia. In Geita region it was discovered that the only aesthetic available was ketamine, which is not appropriate for all obstetric surgical cases. In Mbeya region some of the districts had received BP machines that were not functional and there was lack of resuscitation tables for neonates in one of the facilities visited. In Mbeya region the referral hospital had no postnatal ward and the entire facility had only one specialist, a paediatrician. Most maternal cases were referred to a private health facility for proper management.

Between May and August 2011, Sikika did a rapid assessment of 100 health facilities and found that 29 suffered stock-outs of essential medicines and supplies. Sikika calculated that budgets for essential medicines were only 40% of the required budgets, and questioned priority setting.

Infrastructure

The MOHSW has standards to be used for construction of dispensaries health centres, and hospitals. These are supposed to be adhered to during the on-going new constructions under the MMAM. However during discussions with stakeholders, it was expressed that the MOHSW is not always consulted to provide the standards. At the facilities visited during the MTR, the labour wards were found to be run down, in need of renovation, and too small. Especially at the district hospitals, congestion was observed. There was also lack of running water and light sources. In some facilities toilets have been constructed far from the ward making it very inconvenient for a woman in labour. Hospital beds, including delivery beds had no proper mattresses and covers, making it difficult to ensure hygiene and infection control.

The policy to have all women deliver at health facilities may mean that women deliver in some facilities without adequate space for delivery and postnatal wards, and without skilled providers in view of the anticipated increase in the number of facility deliveries targeted by the Roadmap. Women are being discharged earlier than recommended after delivery, simply to create space for those who have not delivered. This was observed in Rungwe district during the MTR field visit. With the on-going construction of new facilities under MMAM, the infrastructure standard for dispensaries and HCs need to be revised to ensure there is provision of adequate space for delivery rooms and postnatal wards, as well when undertaking renovation of facilities.

3.4.3 Advocacy

In the wake of MDGs, the MNCH has enjoyed high level political commitment. The One Plan Roadmap was launched by his Excellence the president of Tanzania, Dr Jakaya Kikwete, under the slogan “Deliver Now for Women and Children” in Tanzania. The national efforts to reduce maternal newborn and child deaths are complemented by a number of international and regional drives focused on achievement of MDG4 &5, in which the president is directly engaged.

Following the launch of the global program “Every Woman Every Child” in 2010 by the UN Secretary General, His Excellence President Jakaya Kikwete was chosen to co-chair the Un Commission on Information and Accountability. This also helped to elevate MNCH issues at national level, and Tanzania has been in the forefront in the implementation of the recommendations of the Commission. He has for example directed the implementation of data monitoring, using the agreed national MDG 4 & 5 indicators and to comply to global requirements for MDG reporting. In 2009 the Africa Union launched its campaign on accelerated reduction of MNC deaths in Africa (CARMMA). Tanzanian launched its CARMMA chapter in 2011 as a high profile advocacy event, which involved ministers and parliamentarians.

A number of advocacy activities have been supported aimed at advocating for increased budget allocation for MNCH interventions including FP and nutrition. Advocacy has also focused on revision of laws, legislations and policies that hinder effective provision of MNCH services. Health Promotion Tanzania (HDT) led a team of 11 advocates from CSOs working in RH including FP in Tanzania. This project was supported by the Gates-funded Advance FP project in Tanzania, and advocacy was conducted between April and August 2012. In May 2013 there was a launch of the food fortification programme by his Excellence the president of Tanzania, Dr Jakaya Kikwete.

The White Ribbon Association (WRA) is actively lobbying in Tanzania and also follows up on the commitments made by government relating to improving MNCH, such as having a health centre in each division and increase availability of CEmOC. Currently in 2013 WRA is undertaking an assessment of CEmOC coverage starting with Rukwa region. WRA proposes a budget line for CEMOC in the CCHPs, as well as in the central government budget. WRA advocates follow up on how this budget line will be utilised.

Another advocacy forum is the Policy Forum, which is a network comprising of over 100 Civil Society Organizations (CSOs). Its common interest lies on issues relating to poverty reduction, equity, and democratization, all with a specific focus on governance and accountability. The forum conducts Monthly Breakfast Debates on various policy topics, the policy forum also conducts quarterly Meetings to consult, strategize and share information their work. There is also the Interfaith Standing Committee on Economic Justice and the Integrity of Creation (ISCJIC). One of the committees objectives is to effectively advocate for social and economic justice as part of advocating for the rights of the marginalized, the poor, and the voiceless as a necessity in most faiths.

3.4.4 Community involvement (CHW)

With regards to community involvement MOHSW developed National Integrated Community Maternal, Newborn and Child Health Care Guidelines aimed at providing direction to all stakeholders in implementing community MNCH services. Training guides for community workers are also available.

The MOHSW in 2009 conducted a community assessment, which showed high knowledge levels in certain areas e.g. communities were aware of the importance of antenatal care (ANC) and HIV screening during pregnancy. However limited knowledge existed regarding the importance of PNC services beyond immunisation and child growth-monitoring cards. The assessment also documented

barriers to MNCH service use such as lack of transportation, costs associated with delivery in facility and poor attitudes of health providers (Ramsey et al.2013)

The MOHSW-RCH has developed a community based integrated MNCH guideline, to be used by all partners, and is currently being piloted in Morogoro region in partnership with the JHPIEGO- MAISHA project. MOHSW envisages that community MNCH activities will primarily be implemented through home visits conducted by CHWs, providing continuum of care for women (antenatal period, PNC until the child reaches the age of five).

In Tanzania there is an existing network of informal community health workers (CHW) in most of the districts, who perform various health activities. They for example participate in community mobilisation for immunization, provision of health education and outreach MNCH services. Some have been trained in HBC for HIV/AIDS- on Community based counselling and distribution of FP (CBDs), and Community IMCI.

The government of Tanzania is committed to strengthen PHC, expanding access to services and strengthening linkage with the communities. In the MMAM program health care services are planned to extend from community to dispensaries, health centres and to district hospital, with the CHW as the link agent who will have a formal standardized training and will be a part of the health system. There are currently efforts at national level to formalize the cadre. Both the Ifakara training Institute and Iringa PHC has trained three batches (each 50students) with donor support, and they have been deployed in Morogoro and Tanga regions

IEC/BCC is one of the main strategies of the one plan Road Map. A National Communication Strategy for MNCH has been developed. However in discussion with the TWG health education, some were not aware of this strategy. A National Nutrition Social and Behavioural Change Strategy was also launched by President Kikwete in May 2013.

The TWG expressed a general concern that a disconnect exists between the RCH and the health promotion unit. One of the challenges is that each partner/project has its own communication focal person. Often materials are produced without adherence to the national policy; such materials are not always culturally appropriate. The TWG on health promotion seeks to address this by formulating a health communication policy that will be used by all stakeholders. Currently there are several ongoing BCC campaigns by the mass media, on MNCH to promote, early ANC attendance, male involvement, use of SP, facility delivery, etc. An example of MNC BCC is the “Wazazi ni pendeni” which promotes the use of SP during pregnancy to prevent malaria.

4. Governance

4.1 District and Regional Supervision and National Coordination

At regional and district level, in addition to the RCH coordinators, the RMO and DMO provide supportive supervision and mentoring. During MTR visits, the MTR team was informed that supervision schedules are often not adhered to due to budget constraints (for transport, fuel and allowances) and late disbursement of funding. In addition, supervision takes a form of checklists and is often not supportive. There is no time for clinical mentoring. There are also concerns regarding technical/clinical capacity of the supervisors. It has been suggested during the MTR that Regional/ District coordinators should be people who have had additional training on RH/MNCH, at certificate, diploma or degree level. In addition each district should have a trained clinical mentor with a clear job description and activities to be performed on MNCH at lower level facilities, so that the coordinators could focus on planning, implementation logistics and monitoring of MNCH.

At national level there is inadequate financial and human resource capacity to effectively perform the supervision and mentoring roles to the zones and regions. There are over nine programs under this section, which gets meagre government budget. The Development Partners do not budget for supervision by RCH-section and often do their own supervision in the areas they operate. The Roadmap – One plan is not prioritized and costed and so the critical gaps are not highlighted, but rather any initiative that comes up is taken up as a priority area. Partners felt the One Plan is like a shopping list for all activities to be performed without prioritising. As a result a partner can simply select an issue and address that without addressing issues comprehensively e.g. as a package of essential interventions.

Respondents interviewed proposed to elevate the status of the RCH to a directorate level having adequate technically competent persons with adequate clinical skills as well as advocacy and communication skills to support the director. This could enhance the capacity for the RCH section to effectively deal with the big number of partners and provide the necessary country leadership in the implementation of policy and programs.

4.2 TWG Functioning

MOHSW works with Development Partners and (inter)national NGOs working on RH and MNCH. At national level there is a Technical Working Group (TWG) for RCH and sub-TWGs for all the programs under RCH section. The sub TWGs include SMI, Newborn Health, Child health, FP, Contraceptive, Adolescent Health, GBV, Cervical Cancer and EPI. There seems to be some overlaps such as the FP and contraceptives subgroups. The RCH section is the chair and secretariat for and chair the TWGs and sub-TWGs(with selected partners supporting secretariat).

The umbrella MNCH-TWG has clear terms of reference; has its milestones and reports to the Steering Committee for SWAPs. The TWG arrangement avails an opportunity for the RCH section and the partners to plan together and coordinate MNCH issues. Some members have mixed feelings about sub-TWGs: they ensure that specific issues are addressed, but enhance working in silos. Sub-TWGS are less familiar with each other's work even though they report at monthly MNCH TWG.

For EPI there is in addition an interagency Committee on Immunization, which is chaired by the PS MOHSW where the sub-TWGW on EPI reports to.

Another challenge cited was that members of the TWGW do not consistently attend meetings or have lost interest. Some felt that at times issues are raised, but not followed up with requisite action.

Respondents mentioned during discussions that there are too many partners. Currently, the capacity at RCH is inadequate to coordinate all of them. Furthermore, there is a tendency among partners to push their own agendas. The RCH-section has to respond to the work plans of the partners, and has little time for strategizing on high-level policy issues. Another concern was that even with this working arrangement some partners bypass the RCH section and go straight to the district after obtaining permission from the PROMLAG.

4.3 The One Plan Implementation Mechanism

The MNCH strategic plan is implemented in collaboration with relevant stakeholders, and it is aligned to other national development plans including MKUKUTA, national Health Policy, MMAM etc. The specific roles and responsibilities from national to grass root level are clearly stipulated in the plan, including the roles of other Ministries, Departments and Agencies (MDAs).

The One Plan should be clear to stakeholders at various levels. However, some of the RHMT and CHMT members were not aware of the roadmap during the MTR, even though MNCH activities have been included in the Regional and District plans.

Some of the stakeholders interviewed felt that the One Plan Roadmap has not been translated into a workable operational plan and therefore MNCH issues are not prioritised at regional or district level. The stakeholders pointed out a need for a prioritized costed plan linked to the national essential health package and health financing.

Annually MNCH meetings are organized, which bring together Zonal and Regional Coordinators. There are also Regional Forums, which offer opportunity for the districts to share what they are implementing, challenges being faced and discuss how to overcome them.

The MTR team was informed that each implementing partner submits progress reports to the RCH-section. These reports are not routinely collated.

Many partners provide support to the district, but the CHMTs have little say on priorities or actions: these partners come with an authorisation from the MOHSW central level and implement activities as they want which at times disempowers the CHMTs.

Monitoring of activities is done mainly through routine HMIS (which is inadequate to capture data on MNCH including PNC and EMONC) and also using data from development partners. Because there is no clear Operational Plan for the Roadmap, there are no regional targets or indicators to feed into the overall plan. The MOHSW has revised the MTUHA and the national training of providers at all health facilities (at least two per facility) in the country which was initiated in November, 2011 was completed in July 2013. This new HMIS captures all relevant data for MNCH and will enable monitoring and evaluation of the Road Map.

5. Cross-cutting SWOC Analysis

Strengths

- Conducive environment exist, such as a robust policy framework to support improvement of MNCH, demonstrated by a number of policies, plans, guidelines etc.
- High level and political commitment exist to address MNCH, though not yet translated into increased funding allocation.
- Technical expertise is available from the pool of Development Partners for the ministry and other stakeholders to put into practice evidence based interventions.
- A functional political and administrative infrastructure in the country that facilitates access from the national, regional district, ward and village/community level

Weaknesses

- The One Plan provides strategic direction; however, it lacks a clear Operational Plan to enable regional and district level implementation plans.
- Most of the standards and protocols developed are often not available, and therefore remain unknown particularly to health providers at facility level.
- There appears poor linkage between many health facilities and the community. This impacts on referrals to the health facility, especially for pregnant women in labour, as well as on opportunities to promote Community MNCH and FP.
- Despite the high numbers of women making at least one ANC visit, the opportunity is not taken to maximise the number of services that could be provided to pregnant women as seen by low coverage rates for IPT and TTV.
- Inadequate numbers of skilled attendants to provide quality maternal and neonatal health care.
- Limited supportive supervision and clinical mentoring to health workers in facilities.

Opportunities

- Other TWGs can be approached to coordinate on specific issues affecting MNCH including nutrition.
- Community based interventions can be expanded, promoting appropriate health behaviours such as prompt health seeking for pregnant women and children and the involvement of men in MNCH and FP.
- Existing community structures (CBOs, women's organisations and youth groups) can be involved to promote health behaviours and practices regarding MNCH and Reproductive health.

Challenges

- Perceived low quality of care and existing or perceived financial barriers to delivery services, may affect increase of utilisation of reproductive health services.
- The large number of partners of RCH-section (with about 9 programmes) with their own priorities and agendas may undermine the efficiency to addressing MNCH issues.
- A large number of unskilled providers (unofficially) task shifted to provide critical maternal care services including BEmONC

6. Recommendations

Management

- Have an operational national roadmap that is a costed and prioritized essential MNCH package that is translated into CCHP guidelines that are easy to plan and budget and strengthen advocacy for increased national resources for MNCH and FP.
- Plans at national level needs to be cascaded and to be adjusted at regional/district level in line with local needs/priorities to enhance ownership of various RMNCH strategies.
- The RCH-section should prioritise national needs and present them to each implementing partner for support, by defined geographical area, aiming at equitable coverage of services, and providing stewardship instead of letting each partner prioritise their own ideas.
- Local government in collaboration with RCH ensure that partner coverage is in line with national policy, plans and guidelines, and partners collaborates and build capacity/mentoring the local government for programme implementation rather than being implementers on the ground.
- In line with the UN Commission on Information and Accountability for MNCH, utilize existing structures, political and administrative at the PMORALG and LGA to create awareness and establish a mechanism for accountability on MNCH at all levels
- The TWGs and sub-TWGs need to collaborate more so that cross cutting issues are addressed holistically.

Quality& Access

Increase availability of skilled birth attendants, and supervision and support. This will not only improve maternal health care, but also improve neonatal care and reduce neonatal mortality. Integrate HBB training to in-service and pre-service BEmONC training of health providers. Revisit training packages in line with evidences for effective methods for imparting knowledge and skills to incorporate short duration competency based trainings and enabling inclusion of integrated packages together. i.e. FP, BEmONC and HBB together

- Establish clinical mentors and training for BEMONC and CEmONC ensuring the right skills mix (theatre nurse, anaesthetist and AMO surgeon).
- Efforts should be made to improve access to CEMONC services , including scaling up provider training and expansion of HC to provide CEMONC and establishment of subzonal/district safe blood services.
- Create an enabling environment for maternity care such as provision of adequate labour ward space with running water and electricity, construction of staff houses, and the provision of the essential equipment and supplies. The presence of a professional provider alone without an enabling environment will not impact on reduction of maternal /neonatal mortality and morbidity
- Basic neonatal care should be available at every BEmONC facility i.e. dispensaries and health centres. District hospitals should have facilities for Kangaroo mother care.
- Focus on Regions with poor indicators for nutrition such as for stunting and anaemia or other poor performance indicators. Improve in these areas the management of illnesses in children in health

facilities, prompt referral of sick children as well as promotion of appropriate feeding practices at home.

Community

- Provide community-based counselling and health education through well-trained and supported community health workers (CHWs), who are members of and chosen by the community and can therefore be more acceptable due to cultural awareness.
- Utilise CHWs that are formally trained, supervised and employed by the health system in order to provide promotional and preventive health services in general. The training will among other things include a package of maternal and neonatal health related services in the community and the way in which CHWs can engage in risk identification and management, monitoring and evaluation of MNCH.
- Since most child deaths occur at home, community child health interventions should focus on prevention and timely and appropriate action. Intensified community IMCI (C-IMCI) could play a significant role in improving neonatal survival.
- There is need to increase health promotion of healthy behaviours such as exclusive breastfeeding, improved infant feeding practices etc.
- As most of the population live in rural areas, the LGA should develop means to reinforce accountability for maternal and child health and mobilize the community to support pregnant women's and children's access to care including emergency referral

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